Fourth Quarter 2000 Summary of Incidents, Complaints, Enforcement Actions

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SUMMARY OF INCIDENTS FOR FOURTH QUARTER 2000

I-7661 - Radioactive Material Lost and Found - Metco - Orange, Texas

On October 4, 2000,the Department of Public Safety notified the Agency that a radiography device was found near the Texas - Louisiana state line. An Agency investigation determined that the device contained a 97 curie iridium-192 source. A radiography team did not secure the camera in the truck before transportation from a job site to a storage facility. Upon arrival at the facility, the radiographers discovered the camera and a survey meter were missing. The radiographers retraced their route back to the job site. At the time of their arrival the Licensee's General Manager called them and informed them that the camera had been found. The Licensee's radiation safety officer (RSO) had been notified by the City of Orange Police Department that the device had been found at Interstate 10 and Simmons Road in Orange. The RSO proceeded to the location and secured the device. The device had fallen out of the radiography truck because it had not been properly secured for transport in the truck. The radiographers proceeded to the location and the device was placed back into the truck. Leak test results indicated no leakage. The Licensee and the Radiographer Trainer were cited for failure to block and brace the camera during transport and for failure to secure the device against unauthorized removal or access.

File Closed.

I-7662 - Dose Irregularity - Huguley Memorial Medical Center - Fort Worth, Texas

On October17, 2000, the Licensee notified the Agency of a dose irregularity that occurred on October 16, 2000. A patient was administered the wrong dose of a radiopharmaceutical. A technologist selected the wrong syringe and did not read the label. The error was realized when another technologist spoke with the patient and verified the intended procedure. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem, and no organ received greater than 50 rad. To prevent a recurrence, the technologist was instructed to have all radiopharmaceutical doses verified by a senior technologist prior to administration.

File Closed.

I-7663 - Exposure to the Public - H&G Inspection - Houston, Texas

On October 19, 2000, the Licensee notified the Agency of an exposure to the public that occurred on the same day. A maintenance man crossed a catwalk, to where radiography was being conducted on a furnace stack, to conduct end of the day air sampling. The radiographer trainer was on the opposite side of the furnace stack retrieving film from a previous shot and did not see the maintenance man enter the area. No barriers or signs were posted on the catwalk. The maintenance man came to within 2 feet of a 65 curie iridium-192 source during a 20 second exposure. The exposure to the maintenance man was estimated at 533 millirem. The Licensee was cited for exposing a member of the public. The radiographer trainer was cited for failure to maintain visual surveillance of radiography operations, failure to conspicuously post signs for a radiation area, and for failure to use additional signs, ropes, and/or barricades to prevent access to the restricted area.

File Closed.

I-7664 - Unauthorized Disposal of Radioactive Material - Huguley Memorial Medical Center - Fort Worth, Texas

On October 24, 2000, the Licensee notified the Agency that hospital trash activated a radiation alarm at a landfill on October 16, 2000. The trash container was placed in an isolated area until the hospital's radiation safety officer arrived at the landfill. The hospital retrieved the waste and held it for decay. The hospital determined the trash contained bodily fluids from a patient who was injected with a radiopharmaceutical for a diagnostic procedure. Weekend staff did not follow the hospital's internal procedures for disposal of contaminated trash. Contaminated patient diapers and a bedpan were placed in the regular trash without notifying the nuclear medicine staff. To prevent a recurrence, the hospital held a meeting with staff and discussed the proper procedures for disposal of contaminated trash.

File Closed.

I-7665 - Overexposure - X-Ray Inspection, Inc. - Beaumont, Texas

On October 17, 2000, the Licensee notified the Agency that a radiographer had received a 5,290 millirem exposure during the August 2000 monitoring period. An Agency investigation did not find an unusual occurrence that could have caused the exposure. The radiographer and his assistants during the month did not report any unusual occurrences and indicated that their pocket dosimeters did not go off-scale and their alarming rate meters were not activated during the month. The dosimetry service indicated that the badge exposure was a valid exposure. The Licensee was required to remove the radiographer from duties involving occupational exposure to radiation for the remainder of the calendar year. The Licensee was cited for permitting occupational exposure greater than the annual limit.

File Closed.

I-7666 - Badge Overexposure - Odessa Regional Medical Center - Odessa, Texas

On October 18, 2000, the Registrant notified the Agency of a 34,678 millirem exposure to a technologist during the July 2000 monitoring period. The Registrant believes the exposure was only to the badge. The badge processor noted that the exposure was static indicating the badge was not worn during exposure. The Agency concurred with the Registrant's findings. A deletion was allowed and a 163 millirem assessment, based on past average exposure, was accepted.

File Closed.

I-7667 - Stolen X-Ray Equipment - Columbia Medical Center of Lewisville dba Medical Center of Lewisville - Lewisville, Texas

On October 18, 2000, the El Paso Police Department notified the Agency of the recovery of a C-Arm X-Ray machine on July 12, 1999. An Agency review of records indicated that the machine had been stolen on December 8, 1998. The Registrant notified the Agency of the theft on December 11, 1998. The machine was released by the police department to an authorized agent for disposal or sale. The Registrant was cited for failure to secure the radiation machine against unauthorized removal.

File Closed.

I-7668 - Dose Irregularity - Arlington Memorial Hospital / Mallinckrodt - Arlington, Texas

On October 13, 2000, the Licensee notified the Agency of a dose irregularity that occurred on September 19, 2000. A patient was administered a radiopharmaceutical that did not image as expected. The cause of the unusual biodistribution could not be determined. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The Licensee indicated that proper procedures had been followed and no corrective actions were warranted.

File Closed.

I-7669 - Dose Irregularity - Mallinckrodt, Inc. / Harris County Hospital District dba LBJ Hospital - Houston, Texas

On November 3, 2000, the Licensee notified the Agency of a dose irregularity that occurred on October 27, 2000. When a dose arrived at the hospital from the nuclear pharmacy, labels on both the shield and syringe were verified by the receiving technologist. The dose was injected but the imagery results were not as expected. The hospital notified the radiopharmacy and confirmed the dose was mislabeled. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem, and no organ received greater than 50 rad. The patient was rescheduled for the correct procedure. The pharmacist was counseled to check each vial prior to dispensing. The pharmacy informed its staff of the incident and cautioned the staff to double check set-ups prior to filling prescriptions. The pharmacy was cited for failure to correctly label the syringe and the syringe shield. Information concerning this incident was forwarded to the Texas State Board of Pharmacy for possible action under their rules.

File Closed.

I-7670 - Equipment Damaged - Price Construction - Big Spring

On November 4, 2000, the Licensee notified the Agency that a temporary job site was vandalized on the same day. A nuclear gauge containing a 6.1 millicurie cesium-137 source was damaged. A leak test determined the source was not damaged. The gauge was sent to the manufacturer for repair. The local police were notified of the incident. To prevent a recurrence, the Licensee repaired the damaged door and installed a security lock.

File Closed.

I-7671 - Badge Overexposure - The University of Texas, M.D. Anderson Cancer Center - Houston, Texas

On October 24, 2000, the Registrant notified the Agency of a 5,524 millirem exposure to a radiologist during the January through August 2000 monitoring period. An Agency investigation determined that the radiologist performed special procedures involving the use of fluoroscopy equipment. The radiologist used a single badge worn at the collar. The Registrant applied the recalculation provisions of 25 TAC 289.231(m)(3)(B) to lower the radiologist's dose. The Registrant requested deletion of the dose through October 2000 and requested a 1657 millirem assessment based on the recalculation formula. The Agency granted the deletion and accepted the 1657 millirem assessment.

File Closed.

I-7672 - Source Disconnect - General Welding Works - Houston, Texas

On October 31, 2000, the Licensee notified the Agency that a 71 curie cobalt-60 radiography source became disconnected on September 11, 2000. A radiography trainee failed to reconnect two guide tubes after a radiography device was repositioned. The radiography trainer did not realize the connection had not been made. The source was cranked out through the first guide tube and onto the shop floor. Attempts to retract the source were unsuccessful. The radiation safety officer and his assistant were contacted and they responded to the incident. A licensed consultant was hired to retrieve the source. A source leak test indicated no damage to the source. The consultant received a 1,100 millirem whole body exposure during the retrieval. The maximum pocket dosimeter reading for the radiographers involved in the incident was 11 millirem. To prevent a recurrence, the Licensee held a meeting with the trainer and the trainee. The meeting emphasized the need to verify actions during each step of the radiographic process.

File Closed.

I-7673 - Badge Overexposure - The University of Texas M.D. Anderson Cancer Center - Houston, Texas

On November 14, 2000, the Registrant notified the Agency of a 6,958 millirem high energy exposure to a nurse during the August 2000 monitoring period. The Registrant removed the nurse from duties involving occupational exposure to radiation until the investigation was completed. The Registrant's investigation concluded that the nurse had inadvertently left the badge in a therapy treatment room. A deletion was granted and a 10 millirem assessment, based on previous exposure history and average co-workers exposure, was accepted.

File Closed.

I-7674 - Dose Irregularity - Arlington Memorial Hospital - Arlington, Texas

On November 13, 2000, the Licensee notified the Agency of a dose irregularity that occurred on October 27, 2000. A patient was administered a wrong radioisotope. The patient and referring physician were notified of the error. The patient was scheduled for the proper test. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the technologists were instructed to cross check and match procedures with the list of indications approved by the radiologists. Closer supervision was established and the technologists were advised to consult with the authorized users when uncertain of a procedure.

File Closed.

I-7675 - Transportation Incident - Baylor University Medical Center / Best Industries - Dallas, Texas /Springfield, Virginia

On November 21, 2000, the Nuclear Regulatory Commission notified the Agency of a transportation incident. A package, labeled yellow II with a transportation index of 0.4, was shipped from a Texas Licensee to a manufacturer on November 17, 2000. The package arrived with 2,700 millirem per hour radiation levels on the surface and 65 millirem per hour radiation levels at one meter. The package contained iridium-192 seeds. The Licensee's investigation determined that a packaging error locked an iridium-192 seed ribbon outside its shielding. The Licensee did not detect the elevated radiation levels before shipping the package. Exposures to the public were calculated to be less than 30 millirem. The Licensee was cited for failure to ensure package radiation levels were below regulatory limits and failure to properly mark and label the package for shipment.

File Closed.

I-7676 - Radioactive Material Lost - Dow Chemical - La Porte, Texas

On November 27, 2000, the Licensee notified the Agency that radioactive material was determined to be missing on November 15, 2000. The Licensee's investigation determined that an electron capture device containing an 8 millicurie nickel-63 source had been sent to a metal recycling facility. A search of the recycling facility did not locate the device because the scrap is shipped to steel mills daily. Movement of the scrap was done primarily by machines, making personnel exposure unlikely. The Licensee determined the laboratory personnel knew the proper handling procedures for the device but believed the source had been removed. To prevent a recurrence the Licensee: made the radiation warning labels larger for laboratory equipment; provided training on radiation disposal; reviewed the process for disposal of scrap materials at the site; and modified device inventory sheets to include source disposition. The Licensee was cited for the transfer of radioactive material to a person who was not authorized to receive and possess the material.

File Closed.

I-7677 - Dose Irregularity - Medical City Dallas Hospital - Dallas, Texas

On November 16, 2000, the Licensee notified the Agency of a dose irregularity that occurred when a technologist injected a patient with an expired radiopharmaceutical. A nuclear medicine technologist marked the wrong expiration time on the radiopharmaceutical. The error was discovered when the patient could not be properly scanned. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem, and no organ received greater than 50 rad. The technologist was counseled by her supervisor regarding proper procedures and methods to document neurophysiology studies.

File Closed.

I-7678 - Dose Irregularity - Medical City Dallas Hospital - Dallas, Texas

On November 16, 2000, the Licensee notified the Agency that a dose irregularity occurred on October 26, 2000. A patient was administered an incorrect radiopharmaceutical. The wrong study was entered into the computer by a floor nurse and transferred to the nuclear medicine department. The referring physician was notified and he indicated that the examination result would be useful for the patient's care. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, a nursing manager provided training to ensure that nurses correctly enter studies into the computer.

File Closed.

I-7679 - Extremity Overexposure - Century Inspections, Inc. - Dallas, Texas

On November 22, 2000, the Licensee notified the Agency of an extremity exposure to a radiographer during a source exchange inside a radiography vault. The radiographer had connected the cable to the pigtail and was attempting to attach the quick connect from the radiography camera to the source exchanger. There was too much slack in the cable and the radiographer asked another radiographer outside the vault to turn the crank to take up the slack to allow the connection. Apparently the radiographer had inadvertently unlocked the pigtail because the source moved from the shielded position and exposed the radiographer. The radiographer immediately left the vault. The Licensee's radiation safety officer (RSO) heard the vault alarm and investigated. Since the pigtail was connected to the cable the RSO was able to crank the source into the radiography camera. The radiographer was not wearing personnel dosimetry. The radiographer had a calculated whole body exposure of 65 millirem and a worst case extremity exposure to the left hand of 150,000 millirem. The radiographer did not receive a radiation burn, indicating the actual extremity exposure was considerably less that the worst case 150,000 millirem exposure. The Licensee and the radiographer were cited for failure to wear personnel monitoring devices during radiographic operations.

File Closed.

I-7680 - Gauge Involved in Accident - Price Construction - Big Spring, Texas

On December 1, 2000, the Licensee notified the Agency that a truck with a moisture density gauge on board was involved in a traffic accident on December 1, 2000. The truck was parked at a construction site. Another vehicle hit the truck and the impact knocked the gauge from the truck onto the road. The gauge was damaged but the 6.2 millicurie cesium-137 source was undamaged. A leak test of the source verified there was no leakage. The gauge was sent to the manufacturer for repairs.

File Closed.

I-7681 - Medical Event - Cancer Treatment Research Center (CTRC) - San Antonio, Texas

On November 15, 2000, the Licensee notified the Agency of a medical event that occurred during a radiation therapy treatment using a linear accelerator. The Licensee discovered that incorrect positioning for a treatment resulted in a treatment outside the prescribed treatment field. The patient's chart was updated to ensure adjustments to the treatment plan. Appropriate notifications to staff and the patient's parents were made by the Licensee. The Licensee counseled radiation therapists to check treatment setups for each field before beginning treatment. To prevent future recurrence of a similar incident, table positioning tolerances were reduced for the appropriate treatments. An Agency investigation confirmed that the new procedure was in place.

File Closed.

I-7682 - Radioactive Material Found - Structural Metals Incorporated - Seguin, Texas

On September 21, 2000, the scrap metal company notified the Agency that a 1.8 microcurie radium-226 source was found in a load of scrap metal on July 6, 2000. The source was removed from a railcar loaded with shredded metal. A leak test determined there was no leakage. The ownership of the source could not be determined. A licensed company took possession of the source, performed an analysis, and prepared the source for disposal.

File Closed.

I-7683 - Lost Radioactive Material - Memorial Hermann Healthcare System - Houston, Texas

On October 24, 2000, the Licensee notified the Agency of the loss of two - 20 microcurie radium-226, Generally Licensed sealed sources that were components of two liquid scintillation counters owned by the Licensee. During an inventory of equipment after a change of the radiation safety officer, neither liquid scintillation counter could be located. Property management could not document disposal, transfer, or trade-in of either unit or their sealed sources. An extensive search of the Licensee's property storage locations did not locate either unit or the sealed sources. The Licensee was cited for loss of accountability of the two Generally Licensed sources.

File Inactive.

I-7684 - Radioactive Material Lost - Tomball Regional Hospital - Tomball, Texas

On November 16, 2000, the Licensee notified the Agency that a three microcurie cobalt-57 source could not be located. The source was used for marking patients during nuclear imaging. The source had been in inventory since 1997. An extensive search did not locate the source. The Licensee believes the button source was disposed of in one of their radioactive waste shipments.

File Closed.

I-7685 - Dose Irregularity - Memorial Hermann Healthcare System / Syncor Pharmacy Services - Houston, Texas

On November 27, 2000, the Licensee notified the Agency of two mislabeled doses received on November 8, 2000. When the packages were opened by hospital staff, it was discovered that the labels on the syringe shields and the labels on the syringes did not match. A phone call to the radiopharmacy determined that the syringes had been switched during packaging, resulting in the correctly labeled syringes in the wrong syringe shields. After direction from the radiopharmacy, the Licensee exchanged the doses to the proper syringe shield and administered the radiopharmaceuticals. The radiopharmacy determined that the error had occurred during packaging when more than one dose was removed from the dispensing tray for wrapping and delivery. The pharmacy staff has been counseled on the proper way to wrap doses prior to final dispensing. All pharmacy staff members were instructed to only remove and wrap one dose from the dispensing tray at a time. The pharmacy was cited for mislabeling radiopharmaceuticals dispensed to the hospital.

File Closed.

I-7686 - Badge Overexposure - Conroe Regional Hospital - Conroe, Texas

On December 5, 2000, the Licensee notified the Agency of a 5,788 millirem high energy exposure to a technologist during the September 9 - October 31, 2000 monitoring period. The technologist only worked with low energy radiation. A deletion was allowed and a 0.125 rem assessment, based on past exposure history, was accepted.

File Closed.

I-7687 - Dose Irregularity - West Texas Nuclear Pharmacy - Midland, Texas

On December 5, 2000, the Licensee notified the Agency of a dose irregularity that occurred at a hospital on December 4, 2000. The nuclear pharmacy delivered mislabeled bulk radiopharmaceuticals to the hospital. An administered dose produced a scan inconsistent with the expected results. The patient and physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The nuclear pharmacy determined that the labeled vials had been switched during setup and filled with the wrong radiopharmaceutical. To prevent a recurrence of this error the nuclear pharmacy will check the label accuracy and setup prior to filling standing orders for bulk radiopharmaceuticals. A report of the error by the pharmacy has been forwarded to the Texas State Board of Pharmacy for possible action under state pharmacy rules.

File Closed.

I-7688 - Leaking Sources - Computalog Wireline Products - Forth Worth, Texas

On December 14, 2000, the Licensee notified the Agency that a 45 millicurie cesium-137 well logging source was determined to be leaking on December 12, 2000. The Licensee received three new well logging sources from the manufacturer. The source package surface was wipe tested upon receipt, with no contamination detected, but the sources were not leak tested because they were new and had leak test records from the manufacturer. Two of the sources were loaded into well logging tool source holders and shipped to a Licensee's site in Canada. Contamination was subsequently detected on the table top and tools used to load the sources into the source holders. It was thought to be contamination from earlier work. The site in Canada determined the source holders were contaminated, and sent the holders and sources back to the manufacturer for inspection. It was determined that one of the sources was leaking, and had contaminated the other two sources and the shipping containers. All contamination was cleaned and no individuals were exposed to radiation in excess of regulatory limits. To prevent a recurrence of facility contamination, the Licensee will wipe test sources in addition to the outsides of packages.

File Closed.

I-7689 - Dose Irregularity - National Central Pharmacy / Hendrick Health System - Abilene, Texas

On December 18, 2000, the Licensee notified the Agency of a dose irregularity that occurred on December 9, 2000. A mislabeled radiopharmaceutical was delivered by the nuclear pharmacy. The pharmacy discovered the mistake, but before notification could be made to the hospital, the radiopharmaceutical was administered. Imaging confirmed the mislabeling. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence the nuclear pharmacy in serviced all staff members on proper dose verification procedures. The nuclear pharmacy was cited for mislabeling the syringe containing the radiopharmaceutical. A report of the error by the pharmacy has been forwarded to the Texas State Board of Pharmacy for possible action under state pharmacy rules.

File Closed.

I-7690 - Dose Irregularity - All Saints Episcopal Hospital - Fort Worth, Texas

On December 11, 2000, the Licensee notified the Agency of a dose irregularity that occurred on December 1, 2000. A radiopharmaceutical was administered to the wrong patient. A unit clerk sent the wrong request to the nuclear medicine technologist. The technologist did not verify the procedure. The whole body dose was less than 5 rem, and no organ received greater than 50 rad. The patient and referring physician were notified of the error. To prevent a recurrence, the Licensee counseled the technologist.

File Closed.

I-7691 - Dose Irregularity - Baptist St. Anthony's Health System - Amarillo, Texas

On December 8, 2000, the Licensee notified the Agency of a dose irregularity that occurred on November 30, 2000. Two patients were transported from a nursing home to a hospital. Each patient responded to the other's name and one was administered the wrong radiopharmaceutical. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater that 50 rad. To prevent a recurrence of this incident the hospital has instructed that all patients from outside nursing care facilities must have a wrist identification band or their study will not be performed. The Licensee was cited for failure to follow established statements, representations, and procedures contained in their License Condition.

File Closed.

I-7692 - Dose Irregularity - Sierra Medical Center - El Paso, Texas

On December 27, 2000, the Licensee notified the Agency of a dose irregularity that occurred on December 22, 2000. A patient was administered the wrong radiopharmaceutical. A technologist did not verify the correct radiopharmaceutical for the procedure. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem, and no organ received greater than 50 rad. To prevent a recurrence, the Licensee counseled the technologist.

File Closed.

COMPLAINT SUMMARY FOR FOURTH QUARTER 2000

C-1521 - Equipment Malfunction - Dr. Lawrence B. McNally - Dallas, Texas

On October 4, 2000, the Agency received an anonymous complaint alleging that three radiographs were performed on a patient but were of unsatisfactory quality due to equipment malfunction. An Agency investigation determined that only one set of radiographs was performed by the facility on the date alleged. The radiographs were unsatisfactory due to patient movement. The patient was referred to another facility due to lack of cooperation with the x-ray technologist. The allegation could not be substantiated.

File Closed

C-1522 - Regulation Violations - Leta George Electrolysis/ Silhouette Wellness Center/ Smooth Countours/Advansthetics/Valley View Aesthetic Center/Renaissance Laser Hair Removal and Cosmetic Center - Duncanville, Dallas, Plano, Dallas, Dallas, Texas

On September 14, 2000, the Office of the Attorney General referred a complaint to the Agency alleging that six facilities in the Dallas area were providing hair removal services using unregistered lasers and that the procedures were ordered by personnel who were not licensed physicians. An Agency investigation determined that three of the facilities were using intense pulsed light devices that the Agency does not regulate. One of the facilities was appropriately registered with a physician involved with the operation. The remaining two facilities were not registered as required and one of these had no physician involved with the operation of the laser as required. These two noncompliant facilities were cited for the violations.

File Closed.

C-1523 - Regulation Violation - Crystal Woman Foundation - Seabrook, Texas

On October 6, 2000, the Agency received a complaint alleging that the Registrant was not providing original mammograms in a timely manner. The Registrant had transferred all films to a distribution and holding firm. This firm is physically located with the Registrant. The firm does not track incoming faxes and was not accepting generic patient release requests signed by mammography patients. The Registrant was cited for failure to provide original mammograms upon request and was referred for Escalated Enforcement action due to repetitive valid complaints and their compliance history.

File Closed.

C-1524 - Regulation Violations - Professional Service Industries, Inc. - Deer Park, Texas

On October 4, 2000, the Agency received a complaint alleging nuclear gauge utilization logs are incomplete and gauges are transported improperly. An Agency investigation determined the utilization logs were complete and current. A separate log was maintained for each gauge. The most current logs were kept locked in the storage room with the gauges. The transport vehicles were equipped with locks and chains for the proper transport of gauges. No gauges were observed in transport during the investigation. The allegations could not be substantiated.

File Closed.

C-1525 - Regulation Violation - Lotus, L.L.C. - Andrews, Texas

On October 27, 2000, the Agency received an anonymous complaint alleging that the Licensee had their corporate radiation safety officer filling two positions, one as radiation safety officer (RSO) and the other as a trainer for facilities throughout the state. Allegedly, when the corporate radiation safety officer is away from the licensed facility in performance of training duties, the licensed facility is left without an RSO. A review of the license determined that the corporate RSO "may designate other individuals to perform functions commensurate with those of the radiation safety officer in his absence." These designated individuals are referred to as NORM supervisors and have the same authority as the corporate RSO. The complaint was determined to be invalid.

File Closed.

C-1526 - Regulation Violations - Hill Country Sports Medicine - Austin/San Marcos, Texas

On November 3, 2000, the Agency received an anonymous complaint alleging an uncredentialed technologist was performing radiographs at two locations. An Agency investigation substantiated the allegation. It was also determined that the Registrant failed to notify the Agency, in writing, within 30 days of the change of radiation safety officer. The Registrant was cited for the violations.

File Closed.

C-1527 - Unregistered Therapy Center - AHA Cancer Center - Jourdanton, Texas

On November 1, 2000, the Agency received a complaint alleging that a cancer therapy center was treating patients and was not registered as required. An Agency investigation substantiated the allegation. The facility was cited for the violation.

File Closed.

C-1528 - Regulation Violations - Orthopedic Specialists - Texarkana, Texas

On November 21, 2000, the Agency received a complaint alleging a Registrant allowed uncredentialed technologists to perform radiographs and bone density studies. An Agency investigation determined that two individuals who operated x-ray equipment were uncredentialed. The Registrant was cited for the violations.

File Closed.

C-1529 - Unregistered Laser Facility - Tricia L. Prior dba Rocky Mountain Laser Clinic - Austin, Texas

On December 5, 2000, the Agency received an anonymous complaint alleging that a laser was not registered with the Agency and was not operated under the supervision of a physician. An Agency investigation determined that the facility had been registered with the Agency since February 2000. The physician who signed the Application for Registration works from a seperate office providing indirect supervision, which is allowed by regulation. The complaint was not substantiated. The complaint has been forwarded to the Texas State Board of Medical Examiners for possible action under their rules

File Closed.

C-1530 - Laser Injury - North Lake OB/Gyn at Medical City dba Park Cities Aesthetics - Dallas, Texas

On December 3, 2000, the Agency received a complaint alleging that a patient received burns during laser hair removal treatments on July 26, 2000. An Agency investigation determined that the facility used Intense Pulsed Light (IPL) devices, equipment not regulated by this Agency. The complainant further alleged that at the time of the injury the operators were not supervised by a physician. This allegation was forwarded to Texas Department of Health's Medical Devices Branch and to the Texas State Board of Medical Examiners for possible actions under their rules.

File Closed.

C-1531- Unregistered Laser Demonstration and Sales - Medical Equipment Designs, Inc., Grand Prairie, Texas

On December 19, 2000, the Agency received an anonymous complaint alleging that a facility was unregistered for laser demonstration and sales and also functioned as a provider of laser equipment for temporary rentals. An Agency investigation on April 17, 2001, confirmed that the facility was both unregistered for laser demonstration and sales and was also unregistered as a provider of laser equipment. The facility was cited for the violations.

File Closed.

C-1532 - Unauthorized Screening - Lifeline Imaging d.b.a. Vital View - Houston, Texas

On March 12, 2001, the Agency received a complaint alleging a Registrant was performing unauthorized screening. An Agency investigation determined the Registrant had a physician onsite and procedures were ordered by physicians. The investigation did not substantiate the allegation.

File Closed.

C-1533 - Regulation Violation - First PET of Houston - Houston, Texas

On December 11, 2000, the Agency received an anonymous complaint alleging that radioactive materials were being used and stored at an unlicenced location. An Agency investigation determined that no radioactive materials had been transported to, used, or stored at the complaint location. The investigation did not substantiate the allegation.

File Closed.

INCIDENTS CLOSED SINCE THIRD QUARTER 2000

I-6792 - Stolen Nuclear Gauge - Austin Bridge and Road dba: Austin Industries - Dallas, Texas

On May 22, 2000, the Fort Worth Assistant Emergency Manager notified the Agency that the Fire Department Dive Team had recovered a moisture density gauge. A check of Agency records indicated the gauge had been stolen on January 9, 1995. The Licensee was notified of the recovery and arranged to pick up the gauge on May 23, 2000. A leak test performed by the Licensee's radiation safety officer indicated no leakage. The gauge was transferred to the manufacturer on July 24, 2000, for decommissioning.

File Closed.

I-7402 - Stolen X-Ray Equipment - Saint Paul Medical Center - Dallas, Texas

On December 11, 1998, the Registrant notified the Agency that an x-ray machine had been stolen on December 8, 1998. The stolen equipment was recovered in Greenville, Wisconsin. An authorized agent for disposal and equipment sale took possession of the equipment. The equipment is currently pending sale by that agent. The Registrant was cited for failure to secure the radiation machine against unauthorized removal.

File Closed.

I-7629 - Laser Injury - RWR Company, LLC, dba: SomaBel Center for Skin & Body Enhancement - Edinburg, Texas

On July 25, 2000, the Registrant notified the Agency that a patient was injured during the application of laser energy for hair removal. An Agency investigation determined that a new technician performed the treatment without a prescription from a physician. The technician used a higher fluence setting than during previous treatments which resulted in the burns. To prevent a recurrence the physician preformed training in skin typing, and established standing orders for appropriate fluence levels for each patient. The facility was cited for performing treatments that were not prescribed by a physician. The incident was forwarded to the Texas State Board of Medical Examiners for possible action under their rules.

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COMPLAINTS CLOSED SINCE THIRD QUARTER 2000

NO COMPLAINTS WERE CLOSED SINCE FOURTH QUARTER 1999

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES REPORTED DURING THE FOURTH QUARTER 2000

NO HOSPITAL OVEREXPOSURES REPORTED DURING FOURTH QUARTER 2000

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES REPORTED DURING FOURTH QUARTER 2000

Beaumont, Texas

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APPENDIX C

ENFORCEMENT ACTIONS FOR FOURTH QUARTER 2000

Enforcement Conference: Salvador P. Baylan, M.D., Wharton, TX - X-Ray

On November 16, 2000, an Enforcement Conference was held with Salvador P. Baylan, M.D. The Registrant's representative attending the conference was Tony Perales, Chief X-ray Technologist. Agency representatives attending the conference were Messrs. Quincy Wickson (Chair), Rick Munoz, and Tommy Cardwell and Ms. Cathy McGuire.

The conference was held as a result of type, number, severity level, and repetitive nature of the violations noted during an Agency inspection conducted at the Registrant's facility on August 25, 2000.

The participants were introduced and the procedure for conducting the Conference was explained.

The violations stated in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Tommy Cardwell.

After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Agency letter of October 23, 2000, indicating compliance with certain violations was issued in error and was rescinded.

2. As a result of the repetitive nature of violation number 1 of the Notice of Violation, an additional response is required for this violation. This additional response shall include steps taken to prevent the recurrence of the violation. This additional response shall be in writing and shall be submitted to the Agency within thirty days of the date of this memorandum.

3. As a result of the repetitive nature of violation number 2 of the Notice of Violation, an additional response is required for this violation. This additional response shall include actual measurements of the minimum field size at the maximum source-to-image distance (SID) for the OEC fluoroscopic x-ray unit and the steps taken to prevent recurrence of this violation. This additional response shall be in writing and shall be submitted to the Agency within 30 days of the date of this memorandum.

4. A review of violation number 3 of the Notice of Violation, determined that the Physicist's report, dated September 22, 2000, would suffice as the equipment performance evaluation for the OEC fluoroscopic x-ray unit. However, as a result of the repetitive nature of this violation, an additional response is required. This additional response shall include steps taken to prevent recurrence of this violation, shall be in writing, and shall be submitted to the Agency within 30 days of the date of this memorandum.

5. A review of violation number 4 of the Notice of Violation, determined that the violation was issued in error. However, it was recommended that a more orderly filing system for the personnel monitoring reports be established and that reports include the registration number of the facility in order to meet the requirements of the regulations.

6. An additional response is required for violation number 5 of the Notice of Violation. This additional response shall indicate the methods used to ensure that the darkroom light leak tests will be performed at the required six month interval and the steps taken to prevent recurrence of this violation. This additional response shall be in writing and shall be submitted to the Agency within 30 days of the date of this memorandum.

7. A review of the operating and safety procedures submitted to correct violation number 6 of the Notice of Violation, determined that the procedures were not adequate. The procedures submitted were not unique to the facility and equipment. The representative was instructed to use the regulatory guide, take the sections of the guide that apply to the facility and equipment and set them forth on a separate document. A copy of the revised operating and safety procedures shall be submitted to the Agency within 30 days of the date of this memorandum.

8. A review of violation number 7 of the Notice of Violation determined that a copy of the applicable regulations stated under condition number 4 of the Certificate of Registration had not been obtained. These regulations shall be obtained within 30 days of the date of this memorandum and a written response to the Agency shall be submitted within 30 days of the date of this memorandum. This response shall indicate that the required regulations are now available.

9. In order to show compliance with violation number 8 of the Notice of Violation, a separate response from Salvador P. Baylan, M.D., is required. This response shall be in writing, shall be submitted to the Agency within 30 days of receipt of this memorandum, and shall include the following:

   a) A written commitment that operating and safety procedures will be reviewed on a regular basis to ensure that the procedures are current, conform with the regulations, and that employees are following the procedures;

   b) A written commitment that personnel monitoring records will be properly maintained and reviewed on a routine basis; and

   c) A written commitment that records required under 25 TAC § 289 will be properly maintained.

10. Unannounced inspections will be conducted at an increased frequency to determine compliance. The inspector will attempt to conduct these inspections on days when the patient workload is minimal.

11. Administrative penalties will be issued if the following occur:

   a) If the responses required are not submitted within the required 30 days or are not adequate;

   b) If future inspections determine that violations are repeated; or

   c) If future inspections discover violations that are severity level I or II.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. He agreed to these items and the conference was concluded.

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